CHAPTER IV

COVERED SERVICES AND LIMITATIONS

CHAPTER IV
TABLE OF CONTENTS

CHAPTER IV
COVERED SERVICES AND LIMITATIONS

INTRODUCTION

The goal of the BabyCare Program is to address and correct two major barriers that negatively affect pregnancy and infant health outcomes: (1) fragmentation and lack of coordination in service delivery and, (2) lack of patient knowledge of and ability to successfully access the health care system.

The BabyCare program includes two components:

- Care coordination is available for pregnant women and infants up to age two who are identified as high-risk.

- Expanded prenatal services are available to any pregnant woman enrolled in Medicaid regardless of risk.

All recipients of BabyCare services must receive certain required service elements which are listed in Chapter II, page 4. This chapter describes the process of providing the Maternal and Infant Care Coordinator (MICC) service elements, which include the risk screen, assessment, service planning, coordination and referral, follow-up and monitoring, and education and support services

The Role of the Physician, Nurse Practitioner, or Certified Nurse Midwife in Completing the Risk Screen

Physicians, nurse practitioners and certified nurse midwives are a critical link between the high-risk pregnant woman or infant and the services available through the BabyCare Program. They are responsible for identifying potential or existing problems through the systematic review of the pregnant woman's or infant's medical/obstetrical/developmental conditions, as well as lifestyle and environmental factors, and making referrals for care directed at preventing or ameliorating those problems. Their documentation of the existence of any risk on the Maternity or Infant Risk Screen (DMAS-16 or DMAS-17) entitles the pregnant woman or infant to the formal case management process and enhanced prenatal services for the pregnant woman. In the hospital, the role of these professionals is especially important in the identification of infants, at the time of delivery, who are at risk for medical, social, and/or nutritional conditions that may affect the development of the child. While this process helps identify those recipients who are at risk, it does not obligate the provider to assume the overall medical responsibility or supervision of the recipient.

The physician, nurse practitioner, or certified nurse midwife may also play an important role as a "primary care provider" through choosing to participate as a member of the BabyCare team that develops the service plan and provides maternal and infant case management throughout the pregnancy and 60 days postpartum, and up to age two for

infants. The BabyCare team consists of the primary care provider, the care coordinator (social worker or registered nurse) who provides maternal and infant case management for the recipient, the recipient and other clinicians such as a registered dietitian and certified health education instructors who provide nutritional and educational assistance to the recipient.

DMAS MANAGED CARE PROGRAMS AND BABYCARE

DMAS managed care programs, MEDALLION, Medallion II and *Options*, play an important role in determining how the pregnant woman or infant receives BabyCare Services.

If the recipient is enrolled in the MEDALLION program, he or she has a mandatory designated Primary Care Provider (PCP) who is responsible for providing primary care services, making appropriate referrals, and overseeing the patient's medical care. MEDALLION is a mandatory statewide Medicaid fee-for-service Primary Care Case Management Program (PCCM) for the Aged, Blind and Disabled (ABD) and enrollees participating in the Temporary Assistance for Needy Families (TANF) programs. For a complete explanation of the MEDALLION program, refer to the MEDALLION supplement to this manual.

The MEDALLION PCP assigned to the recipient, as well as the recipient's obstetrician/gynecologist (or other prenatal care provider if different from the PCP) in the case of a pregnant recipient, must be a part of the BabyCare team. These team members must be informed by the BabyCare coordinator about the risks identified, the services provided to address those risks, and the outcomes of the recipient's BabyCare participation in order for the PCP and OB/GYN to provide appropriate medical care and to document the patient's medical record.

Medallion II is a mandatory Medicaid Health Maintenance Organization (HMO) program, which requires ABD and TANF recipients to choose a participating Medicaid HMO to provide most Medicaid-covered health care services. *Options* is a voluntary Medicaid HMO program for ABD and TANF recipients to choose either to select an HMO or to participate in the MEDALLION PCCM program.

Medicaid HMOs participating in Medallion II and *Options* are contractually required to have a BabyCare "look-a-like" program targeted to the populations traditionally served by the DMAS BabyCare Program. Recipients should be referred to their HMO or their HMO case manager should be contacted to enroll the recipient in the HMO's BabyCare program. DMAS will not reimburse BabyCare providers for services rendered to recipients enrolled in HMOs. All of Central Virginia and Tidewater are Medallion II managed care areas (effective April 1999). To determine if a recipient is enrolled in either a Medallion II Medicaid HMO or in the MEDALLION PCCM program, check the recipient's Medicaid Identification Card. The provider also may call the Audio Response System (ARS) (see page 3) or the Managed Care Helpline at 1-800-643-2273. (See page 3 for additional information on the Audio Response System.)

Referral for Maternal and Infant Care Coordination Services

The delivery of maternal and infant care coordination services begins with the completion of a risk screen and a referral to a Maternal and Infant Care Coordinator (MICC) provider. The referral must be discussed with the recipient by the person who completes the risk screen.

The referral can be accepted by the provider of MICC only if at least one medical, social, or nutritional risk factor has been indicated. The term "primary care provider" as used in this manual for fee-for-service recipients refers to the physician, certified nurse midwife, or nurse practitioner under physician supervision, who has assumed overall medical responsibility for the supervision of the recipient. (See “EXHIBITS” at the end of this chapter for a sample of the Maternity Risk Screen and the Infant Risk Screen.) The term “primary care provider” or “PCP” for recipients enrolled in MEDALLION means the physician or clinic to whom the recipient is assigned, who is responsible for the provision of primary care, making appropriate referrals, and managing the recipient’s total care.

Recipient Enrollment in Care Coordination

For recipients who will be opened to care coordination, the MICC must forward the enrollment packet (risk screen, care coordination record, service plan, and letter of agreement) to DMAS within 45 days of the receipt of the referral. Priority should be given to those women who are at greater risk for a negative birth outcome. Infants with high-risk factors should also be considered a high priority. (Example: Although any pregnant teenager may be referred as at risk, the MICC should prioritize a referral for an individual with severe medical conditions or one who is non-compliant with medical conditions.)

Priority should be given to those women who are at greater risk for a negative birth outcome. Infants with high-risk factors should also be considered a high priority. (Example: Although any pregnant teenager may be referred as at risk, the MICC should prioritize a referral for an individual with severe medical conditions or one who is noncompliant with medical directions.)

The activities required to initiate care coordination include the verification of the individual's Medicaid eligibility, an explanation of the program's benefits, the recipient's obligations, and the development of a complete assessment and service plan. Each step is completely described below. The recipient shall be contacted by the care coordinator immediately upon receipt of the referral and risk screen to confirm eligibility and explain the services.

1. **Determine the current status of Medicaid eligibility:** If the recipient's eligibility status is unknown at the time of the first contact, ask the recipient if she has a current Medicaid eligibility card or other documentation, such as a letter from the local Department of Social Services (DSS), on her eligibility status. A Medicaid eligibility card indicates the client is eligible for all Medicaid-covered services for the dates shown on the current Medicaid card.

a. If the THROUGH date has expired, ask if the recipient has a more recent card.

b. If the response is negative, call the Audio Response System (ARS) to obtain the current information. ARS numbers are:

1-800-884-9730	
(804) 965-9732	Richmond and surrounding counties
(804) 965-9733	Richmond and surrounding counties

c. If the recipient has not been to the local Department of Social Services, refer her for review. DMAS will only make payment for MICC services if the individual has been determined eligible for Medicaid and is in fee-for-service or MEDALLION. If the recipient is enrolled in an HMO, the HMO has a program similar to BabyCare.

2. **Explain Maternal and Infant Care Coordination (MICC) Services to the recipient. MICC services are designed to assist the recipient by:**

a. Assessing the recipient's service needs;

b. Developing a service plan with input from the primary care provider to help ensure the best possible pregnancy/infancy outcome based on the recipient's need for:

(1) Medical care;
(2) Nutritional services;
(3) Patient education;
(4) Transportation;
(5) Homemaker or home health care;
(6) Child care; and
(7) Other services.

c. Helping locate providers and services;

d. Assisting in arranging for transportation when needed;

e. Assisting in planning visits to providers and arranging for written referrals;

f. Helping to complete forms/paperwork when required by other programs;

g. Working with providers, especially the primary care provider's office, to ensure the service plan is followed and revised if anything changes;

h. Listening to the pregnant woman's or caretaker's problems and concerns about the pregnancy or childcare, and integrating these into the service plan;

i. Helping the recipient plan for the continuing health care of her child;

j. Providing information about other services available within the community for the recipient's use; and

k. Providing and reinforcing information related to high-risk conditions above and beyond routine teaching.

3. **Explain the recipient's right's and obligations as a MICC recipient, and obtain the recipient's signed agreement. If the recipient chooses to receive MICC services for herself or her infant, she must:**

a) Understand that the services are voluntary, and she has freedom of choice in selecting the MICC and other service providers.

b) Select a Medicaid-enrolled primary care provider (PCP) if she is not already enrolled in the MEDALLION program and assigned to a MEDALLION PCP for her or her child;

c) Agree to work with the MICC to jointly develop a service plan based on her identified needs;

d) Agree to a "good-faith" effort to follow the service plan of care as developed by the primary-care provider, the MICC, and the recipient; and

e) Sign the letter of agreement and service plan expressing commitments of the MICC and the recipient (see "EXHIBITS" at the end of this chapter for a sample of this agreement).

BABYCARE ENROLLMENT AND DISENROLLMENT QUESTIONS

All provider questions concerning recipient enrollments and disenrollments will be handled as follows. The provider must submit, **in writing**, the following information:

- The provider name;
- The provider number;
- The contact name and telephone number;
- The recipient name and Medicaid ID number(s); and
- The specific details of the problem associated with each listed recipient ID number.

Submit the written information contained on the form called BABYCARE ENROLLMENT/DISENROLLMENT PROBLEMS (see "EXHIBITS" at the end of this chapter for a sample of this form). Use of this form is recommended but not required. Photocopies of the form are acceptable. The provider may fax the information to DMAS at 804-786-5799 or mail it to:

Managed Care Unit

Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Attention: BabyCare

A BabyCare analyst will research the problem(s). If more detailed information is needed, the analyst will contact the provider by telephone. Once the problem(s) is resolved, the analyst will respond to the provider, in writing, detailing the resolution.

Direct all other provider questions to the DMAS Provider HELPLINE at 1-800-852-6080.

COMPLETING THE CARE COORDINATION RECORD

The MICC must schedule a home visit to complete the demographic and comprehensive assessment portions of the care coordination record (see "EXHIBITS" at the end of this chapter for a sample of these forms), develop the service plan, and establish the tracking necessary for follow-up and monitoring of care, as specified in this section. All of the following items are to be completed for all recipients of care coordination, unless otherwise specified. The MICC must make a home visit within 10 days of the receipt of the referral to complete the assessment, and initiate care coordination services.

1. **Recipient demographic information** must include:

   a. The recipient name, date of birth, race, marital status, education, Social Security Number, Medicaid eligibility number, and occupation;

   b. The recipient address, city or county of residence, telephone number where she can be reached;

   c. The name of the primary care provider, the number of weeks gestation when prenatal care began (or the age when infant care began), the date of the first MICC contact, and the estimated (or actual) date of delivery; and

   d. Caretaker information should be provided when completing the Infant Care Coordination Record (DMAS-51).

2. **The psychosocial assessment** must include documentation of the problems/concerns which are communicated by the recipient and those that have been identified by the MICC. The following topics must be discussed with the recipient and problem areas recorded in the recipient record:

Topics for the High-Risk Pregnant Woman

   a. **Previous Pregnancy or Parenting Experience** - If this is not the recipient's first pregnancy, the MICC must discuss with the recipient her feelings regarding any previous pregnancies and any other children. The MICC should be particularly aware of any negative experience that may affect prenatal care or pregnancy outcome. Examples of questions to ask:

Tell me about all of your pregnancies (e.g., abortion, miscarriage, premature delivery, problem pregnancy, difficult delivery, stillbirth, infant death, gave baby up for adoption). Do you have any concerns about the pregnancy? Your children? Do any of your children have a health problem? How does what happened make you feel about this pregnancy?

b. **Available Support** - The MICC must discuss with the recipient her perception of the attitudes of significant others, including the baby's father, family members, and friends. It is important that the recipient have emotional support, support for labor and delivery, and someone with whom she can talk. Examples of questions to ask: What is your relationship with the baby's father? Do you have family or friends living close to you? Whom can you ask for help, or talk to about problems?

c. **Significant Apprehension/Anxiety** - The MICC must observe the recipient for signs of extreme apprehension/anxiety and assess the recipient's emotional state. Discuss with the recipient her satisfaction/happiness with her life and this pregnancy. Examples of questions to ask: How do you feel about the way things are going for you? Do you ever get so anxious that you have trouble doing what you would normally do in a day? Are you having trouble sleeping? Are you taking any medication for your nerves or depression?

d. **History of the Use of Drugs, Alcohol or Tobacco** - The MICC must try to determine the recipient's use of any non-prescribed medication/drug prior to or during pregnancy. Examples of questions to ask: Have you used any type of medication since you found out you were pregnant? Have you ever smoked marijuana, taken pills, done "coke" or used other types of drugs? Have you used any of these drugs since you found out you were pregnant or since the baby was born?

The MICC must discuss with the recipient her current and past use of tobacco. Examples of questions to ask: Have you smoked any cigarettes during this or a previous pregnancy? Do you smoke cigarettes now? How many packs a day?

The MICC must explore the recipient's use of alcohol in as non-judgmental a manner as possible. Examples of questions to ask: Has anybody in your family ever had a drinking problem? Do you ever drink any wine, beer, or mixed drinks? How much can you drink at one time? How much are you drinking now?

(**NOTE:** The MICC must advise the recipient to discontinue smoking, use of alcohol products, or any non-prescribed drugs. The recipient must be encouraged to inform the primary care provider about drugs prescribed by other physicians.)

e. **Religious, Ethnic, and Cultural Factors Which Might Affect the Delivery of Prenatal Care or Pregnancy Outcome** - Issues which may

be explored with the patient include cultural values or practices and religion, such as Christian Science or Jehovah's Witness. Examples of questions to ask: Is there anything about prenatal care, delivery or postpartum care that goes against your personal beliefs (e.g., having a pelvic exam by a male physician or accepting a blood transfusion)?

f. **Conflict/Violence in the Home** - The MICC must explore the potential for either partner or child abuse through observation and discussion. Any unusual marks or bruises on the recipient or a child must be noted. Examples of questions to ask: How are things going at home? How do persons in your home act when they are very angry? How do you get your children to mind you (e.g., yell, spank, whip, sit in the corner, etc.)? Do you feel that your home is a safe place for you and your baby to live?

g. **Health Care Needs of the Family** - Inquire about the general health status of family members. Examples of questions to ask: Are any family members under a doctor's care? Where do you usually take your children for health care? For what are they being treated?

h. **Adequacy of Food Resources** - Examples of questions to ask: Do you feel as though there is enough food in your home for you and your family? Do you ever run out of food?

i. **Receiving Food Stamps and WIC** - Examples of questions to ask: Are you currently receiving Food Stamps for yourself or your children? Have you received Food Stamps in the past? Are you or your children currently receiving WIC? Have you applied for the WIC program? When are you going back to the WIC office?

j. **Planning Ability** - Does the recipient have the ability to plan for her and her family's needs? (e.g., returning to work, child care, necessary clothes and equipment.)

k. **Motivation** - To what degree is the recipient able to anticipate problems, solve problems? Does she take interest in herself and/or her situation?

l. **Child Care Needs** - Examples of questions to ask: Who will take care of the baby when he or she is born (the recipient, grandmother, daycare, etc.)? Do you have someone to help you care for your children? Do you have any problems keeping appointments because there's no one to care for your children?

m. **Housing Needs** - Examples of questions to ask: What is your home like? Are you satisfied with where you live? Do your kitchen appliances work? Do you have running water/indoor plumbing? Do you have any other problems with your housing; for example, lack of electricity or heat? Are there rodents or insects in your home? Where do you plan for the baby to sleep or play?

n. **Transportation Needs** - Examples of questions to ask: How do you

usually get to your appointments at the doctor's office (clinic), social services, or other places? Are there any problems using this transportation?

o. **School/Vocational Status** - Examples of questions to ask: Are you in school now? Are you having problems in school because you are pregnant? Were you in school before you got pregnant? Are you interested in going back to school or into job training after you have the baby?

p. **Employment Needs** - Examples of questions to ask: Have you had any problems at work since you became pregnant? If so, what kind of problems? Do you plan on going back to work after the baby is born? Do you stand for long hours at a time? Do you commute for a long time each day? What are your hours of work? Can you receive phone calls at work? Do you know your employer's maternity and childcare leave policies?

q. **Homeless** - Examples of questions to ask: Are you in a shelter now? Do you have any friends or relatives who could provide help/shelter?

r. **Neglect** - Examples of questions to ask: Do you feel neglected by family or significant others? Does the father of the baby help you financially or emotionally? Are you trying to manage this pregnancy alone?

s. **Mental Retardation/Emotional Problems** - Is the recipient able to understand teaching, guidance or written information? Has she been diagnosed as mentally retarded or "slow"? Has she ever been admitted to a psychiatric facility? Would she benefit from outpatient therapy at the present?

Topics for the High-Risk Infant

a. **Maternal Absence** - Examples of questions to ask: Is the mother's absence a temporary or permanent situation? Who will care for the child in her absence? Are the child's needs being met by the present caregiver?

b. **Protective Services Case** - Who is the protective services worker involved in the infant's case? Is the child in foster care? Is the child expected to return to the parent?

c. **Poor Emotional Bonding** - How does the child interact with the mother? Does he or she have eye contact with others? Does the infant have symptoms of "failure to thrive?"

The results of the psychosocial assessment provide important information for identifying significant problems that require care coordination services. Document information concerning important needs as defined by the MICC and the recipient. Those components needing further intervention by the MICC must be addressed in the service plan.

Some recipients may need more intensive counseling and support than the MICC can provide. The MICC should be aware of local resources for counseling. The need for additional counseling should be discussed with the primary care provider.

3. **General Medical Assessment** is to assure that medical risk information is complete, to determine the recipient's level of understanding of identified medical risks, and to evaluate the need for support services to reduce and/or remove medical risks. As the recipient may recall and share information with the MICC which was not shared with the primary care provider, all medical risk factors identified by the MICC must be communicated promptly to the primary care provider. The following topics must be reviewed with the recipient and problem areas documented in the recipient record:

Topics for the High-Risk Pregnant Woman

a. **Multiple Gestation** - Perform a risk assessment for multiple gestation (twins, triplets) and alert the primary care provider of the risk. Determine the recipient's knowledge of the signs and symptoms of preterm labor.

b. **Previous Preterm Birth/Low Birthweight Infant** - Has the recipient had previous preterm births or low birthweight infants? Perform a risk assessment for preterm birth and alert the primary care provider of the risk. Determine the recipient's knowledge of the signs and symptoms of preterm labor.

c. **History of Genetic Disorder** - Does the recipient have a family history of genetic disorders? Is she at risk due to factors such as age? Does she understand the risk? The recipient may need genetic counseling and/or a referral to a genetic center.

d. **Medical Condition Affecting Pregnancy** - Does the recipient have a chronic illness, such as diabetes or hypertension, which may have implications for the pregnancy?

e. **Knowledge of Risk Factors** - Does the recipient understand her medical condition and the care plan prescribed by her primary care provider? Does she have the ability to follow through with the plan of care? Examples include:

(1) An insulin-dependent diabetic who needs to follow a therapeutic diet, adjust medication, and test her blood sugar; and

(2) An understanding of and the ability to obtain high-risk care at a perinatal center.

f. **Pregnancy Information** - Does the recipient have knowledge about

pregnancy, labor and delivery, postpartum care, and family planning? Open-ended questions should be asked to determine the need for one-to-one or group education.

g. **Previous Fetal Death** - Has the recipient had a previous fetal death? If so, a risk assessment for fetal death should be completed, and the primary care provider should be notified. Did the recipient have any counseling following the death of her infant? A referral may be appropriate for mental health services.

h. **Access to Services** - Has the recipient selected a delivery physician, delivery hospital, and a physician to care for the infant? Are there providers in the area who will take Medicaid? Does the recipient have difficulty in accessing services or resources such as social services, transportation, or education?

i. **Advanced Maternal Age** - Is the recipient 35 years of age or older? If so, is this her first pregnancy? Is she aware of the increased health risks due to advanced maternal age? Does she need an amniocentesis or referral for genetic counseling?

j. **Multiple Providers** - If the recipient has multiple providers of care, does she experience conflicting priorities, fragmentation of care, or multiple appointments with transportation and child care problems?

Topics for the High-Risk Infant

a. **Apnea** - Has the mother of the infant been advised that her child has apnea or respiratory problems? Is the infant on a monitor at home? Does the mother understand the life-threatening risks?

b. **Sibling Morbidity/Mortality** - Have siblings of the infant died or suffered serious health problems in infancy? Why? Does the infant's caretaker understand potential risks and possible safeguards regarding this infant's health?

c. **Genetic Disorders** - Has the infant's condition been called genetic? Has the caretaker received an explanation and counseling? Can she describe the risks for future pregnancies, if any?

d. **Chronic Illness** - If the infant has a chronic illness or medical condition, can the caretaker describe the condition, relate it to differences and similarities of infant care if the child was "well," and relate the need for acute medical attention in certain situations? Can she recognize deterioration? (Example: Does the mother of a baby with congenital adrenal hyperplasia know her baby can go into shock with a fever and that she must take the baby to a hospital emergency room and ask for cortisone?)

e. **Lack of Risk Knowledge** - Does the caretaker understand the risks

identified for this infant such as inappropriate diet, prematurity, and noncompliance with medical plans?

f. **Drug Exposure in Utero** - How long has the mother used drugs? Does she continue after the birth of the infant to use drugs? What type of drugs did she use? Has she had counseling/treatment? Has the infant been assessed for the effects of drug use in utero?

g) EPSDT – Has the infant been referred for or received the initial and periodic screenings (well child exams and immunizations)?

h) **Access to Care** - Are there providers in the areas who will take Medicaid? Is a specialist available? Does the caretaker have transportation and child care for other children if children are unwelcome in provider settings?

i) **Developmental Delays** - If the infant has delays, are they considered permanent, resolving, or not known? What interventions have been suggested? Which interventions are available in the community? If not paid for by Medicaid or another service, can the family afford them? Are there vision or hearing problems? If so, what therapy was suggested? Does the caretaker need to learn any special way of handling or relating to the infant? Does the infant have a mobility problem? What has the caretaker been told about sitting and crawling? Has the infant been referred to or is receiving services from Virginia's Early Intervention Program or from Children With Special Health Care Needs or other services?

j) **Caregiver Handicap** - What type of handicap does the caregiver have? Does it affect the care of the child? Does the caregiver need assistance in obtaining special equipment? Would a referral to a support group be appropriate?

k) **Multiple Providers** - Are the providers aware of each others' care plans, such as scheduled surgery? Are there conflicting care plans? Are appointments realistic? (Example: An infant with meningomyelocele has three different surgical appointments and three therapy appointments on two different days in two city provider settings. The caretaker is from a rural area and, after the first day, goes home exhausted and does not return.)

l) **Low Birth Weight** - If the child was low birth weight, is he or she being followed for developmental delay? Has the infant had referrals for infant stimulation therapy? Is the child gaining weight adequately now? Does the parent understand the signs of normal/abnormal development? Has the infant been referred to or is receiving services from Virginia's Early Intervention Program or from Children With Special Health Care Needs or other services?

4. **Nutritional Assessment** is to determine if there are any barriers to good

nutrition and appropriate weight gain of the pregnant woman or infant. Pregnant women with nutritional risks may be referred for a nutritional assessment. Infants are not eligible for Medicaid-covered prenatal nutritional services. Any identified nutritional risk should be discussed with the primary-care provider.

Good nutrition and adequate weight gain are essential for a healthy baby. All women should be encouraged to eat a nutritious diet, gain an appropriate amount of weight, and participate in the Women, Infants and Children Supplemental Food Program (WIC) and Food Stamp programs, if eligible. Those who have certain high-risk conditions may need additional assessment and counseling. To help determine which recipients can benefit from referral to nutritional services, the following questions and concerns must be explored:

Questions for High-Risk Pregnant Recipients

a. **What was your weight before becoming pregnant?**

b. **Consult the weight chart which defines underweight.**

c. **How much weight have you gained?** If less than 90 percent of the standard weight before pregnancy, the recipient should be expected to gain at least 3 pounds during the first trimester and approximately 1 pound per week during the second and third trimesters. If prepregnant weight was more than 90 percent of the standard weight, weight gain should be approximately 3 pounds during the first trimester and a minimum of 2.25 pounds per month following the first trimester. If the recipient is severely obese (135 percent of the standard weight), her physician may have more restrictive weight gain guidelines. Inadequate weight gain in underweight pregnant women and women within the normal weight range can seriously compromise the outcome of pregnancy and should be addressed whenever it occurs. Underweight women and women with inadequate weight gain may be referred for expanded nutritional services.

d. **Is the weight gain excessive?** For normal or overweight women, excessive weight gain, as described in the risk screen instructions, is more than 7 pounds per month for two or more months in the second and third trimester. Underweight women and teenagers may gain more than 7 pounds per month because they need to build stores of food/energy supply that are at a deficit. Excessive weight gain should be evaluated to see if it is due to fluid retention or to overeating.

e. **Do you have diabetes, hypertension, anemia, etc.?** Inquire about any medical condition which may need counseling regarding a special diet.

f. **Have you had a special diet prescribed?** Inquire about the recipient's being able to follow her special diet and if she needs additional instructions. This may require asking about her daily food intake to

determine if she is following her diet.

g. **Do you have nausea, vomiting, etc.?** How frequently does it occur? Do some foods cause it more than others?

h. **Do you have cravings for anything, either food or non-food, such as starch, clay, dirt, ice?** Laundry starch is a common non-food item eaten by pregnant women. In some areas, clay and dirt are also used. Non-judgmental questioning must be used to learn about these items.

i. **Has anyone talked to you about the foods that you should be eating during this pregnancy?** Are you able to regularly eat the recommended foods? Inquire about instructions received from the physician, nurse, WIC Program, etc. Basic nutrition education should be provided by these programs. If basic information has not been provided, refer to the WIC Program or provide some basic information to the recipient. To follow-up, inquire about the current food intake.

j. **Do you have refrigeration, cooking facilities, and a way to go shopping for food? Do you use Food Stamps, use WIC vouchers, etc.?** Ascertain whether the recipient is able to cope with the limitations of poor facilities, food shopping problems, etc.

k. **Are you 18 years of age or younger?** Young teenagers have increased nutritional needs to meet the demands of their own growth and development plus that of their infants. A good diet and adequate weight gain are essential.

l. **Do you have anemia?** Has the recipient been diagnosed with anemia? Does she have food supplements or vitamins? Does she know what foods are high in iron?

<u>Questions for High-Risk Infants</u>

a. **Is the infant enrolled in WIC and are benefits being received.**

b. **Do you understand instructions about feeding the infant, such as the times, amounts, proper cleansing of bottles, introduction of solid foods, etc.?**

c. **If the infant is breastfeeding, are there problems or do you need further assistance?** If further assistance is needed, a referral may be made to a support group such as the La Leche League, or the health department breastfeeding counselor.

d. **Does the infant require a formula other than traditional milk-based formulas, such as Enfamil, Similac, or SMA?** If so, what are the conditions requiring it? Do you understand preparation methods, and can you get the formula easily, etc.?

e. **Does the infant have any condition which requires modification in diet, feeding technique, or equipment?** This includes congenital anomalies, metabolic disorders, diseases requiring diet modification, etc. Has a special diet been prescribed and, if so, are you knowledgeable about the diet?

f. **Is the infant able to suck adequately?** If not, refer the infant back to the primary care provider for further evaluation. An infant with poor sucking ability may require special feeding management.

g. **Has the infant had problems with severe cases of vomiting and diarrhea?** If so, the infant must be referred to the primary care provider. Following recovery, attention must be paid to the infant's diet to assure the adequacy and replacement of losses during illness.

Occasionally physicians may prescribe a change in diet (boiled skim milk, ginger ale, etc.) during the illness, which should be discontinued after recovery. Do you understand when the infant is to resume a normal diet?

h. **Is the infant's weight gain appropriate, based on standard infant growth charts?** If not, review the total infant food intake with the recipient. Refer the infant to the primary care physician for any indications of failure to thrive or excessive weight gain.

i. **Does the infant have anemia?** Has the child been diagnosed as anemic? If so, does the mother have iron supplements for the child? Formula with iron? Is she able to purchase these items without difficulty?

5. **Significant Findings** - The significant findings section of the Care Coordination record (DMAS-50 and DMAS-51) must be used to document a general overview of the problems identified during the assessment. The coordinator must also use this area to provide additional information about the recipient (i.e., family situation, etc.).

6. **Appointment Schedules** - By tracking recipient appointments, the MICC will be able to assess compliance with the plan of care. This area may be used to document appointments the recipient kept or missed referrals.

7. **Client Referrals – EPSDT and WIC** are mandated services to which each recipient must be referred. Referral dates for EPSDT and WIC and other recipient services must be documented in the recipient's record.

8. **Postpartum Services** - Dates for referral regarding family planning must be documented.

Developing the Service Plan

Service plan development must consist of the following:

1. The recipient's identifying information;

2. Service needs identified on the risk screen and the MICC assessment must be addressed on the service plan. Resolved problems and/or issues the recipient does not wish to address may be documented in the significant findings section of the care coordination record (DMAS-50 and DMAS-51);

3. Interventions for identified problems must be addressed under the "plan" heading of the service plan. This includes all necessary referrals. Proposed follow-up must be documented under the "follow-up" heading of the service plan;

4. Steps taken to assure that the recipient receives services and comprehends the information provided by the MICC and other service providers (see 'EXHIBITS" at the end of this chapter for a sample of this form); and

5. Evidence that the primary care provider is aware of the recipient's acceptance of MICC services must be entered on the service plan or in the recipient's record.

The following interventions must be documented within the record and on the service plan:

1. **Nutritional Component of BabyCare Services**

   a. All recipients not currently enrolled in the WIC Program must be referred for certification. It is important that WIC services be obtained as early in the pregnancy as possible. An appointment date should be established with WIC at the time of the initial MICC interview. Ensure that the recipient has transportation. Confirm the continued participation in the WIC Program. If the recipient has difficulty obtaining food supplements or difficulty following her nutritional plan, the MICC may need to provide assistance.

   b. Pregnant recipients with certain high-risk nutritional conditions must be referred to a Medicaid–enrolled provider of expanded prenatal services for additional nutritional assessment and counseling. Such conditions are: underweight/overweight, inadequate weight gain, excessive weight gain, obstetrical or medical conditions, multiple gestation, delayed uterine growth, anemia, diabetes, hypertension, conditions requiring diet modification, pica, and teenagers 18 years or younger. Nutritional services must be provided by a registered Dietitian (R.D.) or person with a masters degree in nutrition or clinical dietetics with experience in public health, maternal and child nutrition, or clinical dietetics enrolled in Medicaid as a prenatal service provider. The MICC must be aware of local nutritional resources and assist the patient in making and keeping necessary appointments. Either the primary care provider or the MICC may refer the recipient for nutritional services.

2. **Recipient Education/Prenatal Education** - The goal of BabyCare is a healthy mother and child. Education about pregnancy and infant care can promote a

healthier outcome.

a. For the pregnant recipient, the MICC must:

(1) Advise or Discuss with the recipient about the importance of early and continuous prenatal care and immunizations;

(2) Assist the recipient in finding a primary care provider, if necessary;

(3) Ensure that the recipient has and comprehends educational materials containing important pregnancy information;

(4) Provide information on childbirth, parenting and smoking cessation classes located in the community. (Either the primary-care provider or the MICC may refer the recipient to patient education when offered by Medicaid-enrolled providers);

(5) Advise the recipient to avoid the use of alcohol and/or tobacco during pregnancy;

(6) Advise the recipient against the use of any drugs/medications during pregnancy unless ordered by her primary-care provider;

(7) Encourage the recipient to adhere to the primary care provider's plan of care;

(8) Advise about or discuss with the recipient the importance of family planning services and provide educational materials; refer her to family planning services, if not already covered by the medical provider; and

(9) Reinforce the teaching done by other providers.

b. For the mother of the infant, the MICC must:

(1) Advise about or discuss with the recipient the importance of early and continuous well-child care and immunizations;

(2) Ensure that the recipient has the EPSDT brochure and understands the available EPSDT preventive services;

(3) Assist the recipient in finding an EPSDT (Early and Periodic Screening, Diagnosis and Treatment) provider for the infant providing assistance in scheduling initial and periodic screenings and arranging transportation;

(4) Follows up with appointment reminders on EPSDT screenings, reschedules any missed appointments, and tracks EPSDT compliance;

(5) Provide materials on parenting and well-baby care and review the with the recipient; and

(6) Inform the recipient on the use of car safety seats and assist, if possible, in obtaining one.

REQUIRED MICC ACTIVITIES

During the time the service plan is being developed and after it is completed, interaction between the MICC and the recipient is required on a monthly basis or more frequently if indicated. The level of involvement will vary depending upon the number and complexity of problems, the availability of providers/services within the area, the support necessary to get a positive outcome, and the recipient's ability to follow the service plan. The activities of the MICC are expected to exceed these activities which are routinely provided to pregnant women and infants as part of medical/prenatal follow-up. MICC services are provided only to those women and infants whose needs require a higher level of intervention during periods when the recipient would not ordinarily receive prenatal/medical care and supervision. Therefore, the following activities are deemed critical to the successful MICC outcome and must be performed and documented in the recipient record.

1. **Recipient Support**

   The MICC must establish frequent contact, either at the home, office, school, place of business, clinic, or doctor's office. The goal is to build rapport and ensure that the recipient knows the MICC has her best interests in mind. There must be a home visit included as part of the initial assessment and care plan.

   Establish with the recipient the type of support the recipient feels will be most beneficial and an ongoing means for follow-up on at least a monthly basis. If the recipient requests additional home visits, make arrangements for them at the earliest possible time.

   During the last trimester of pregnancy, follow-up contacts must be made at least every two weeks from the 28th through the 40th week of gestation. Contacts must be face-to-face, professional collateral with the recipient or family members (e.g., the grandmother who is the caretaker).

   For the high-risk infant, contact must be at least weekly in the first two months of life. As the parent gains the knowledge and ability to provide for the child's needs, contacts with the parent and collaterals may be reduced to a minimum of monthly. If the MICC determines through her assessment that the child is stable, the child must be closed to care coordination services before the age of two years. The case may be reopened if additional risks develop prior to age two.

2. **Coordination with Other Providers of Care**

The MICC must establish rapport with the recipient's providers of care and obtain agreement on a follow-up schedule to monitor the medical compliance and provide assistance in meeting service objectives.

The MICC must establish contact with providers of care, such as medical or prenatal care providers EPSDT, or WIC, as early as possible. Many providers will not be aware of BabyCare services; therefore, the MICC must:

a. Explain the goals of the BabyCare Program (see "Introduction," Chapter II, page 1);

b. Explain that the MICC intends to support the provider's efforts;

c. Request details of the provider's plan of care;

d. Share appropriate information from the MICC assessment;

e. Arrange transportation, if needed, for appointments;

f. Assist the provider and the recipient in locating resources; and

f. Follow up on provider requests for MICC involvement.

3. **Missed Appointments**

The MICC must keep track of the recipient's medical and other referral appointments and make immediate contact, either face-to-face or by telephone, to determine why any appointment was not kept. The service plan will not work if the problem is not identified and corrected. This contact, therefore, is mandatory.

4. **Tracking**

To successfully accomplish monitoring and follow-up, a system of tracking must be implemented to ensure that contacts between the recipient and providers are made as indicated and to ENSURE THAT THE RECIPIENT RECEIVED SERVICES OUTLINED IN THE SERVICE PLAN. This tracking and the results of any MICC interactions must be documented in the recipient's record.

The required components of tracking and documentation include the:

a. Date of the recipient professional collateral and contact/attempted contact and the type of recipient contact (e.g., home visit, telephone, letter, etc.);

b. Nature or subject of contact;

c. Problems resolved/actions taken since the previous contact;

d. Service plan items addressed during this contact and actions to be taken by the recipient or MICC before the next contact;

e. Modifications to the original service plan;

f. Next scheduled contact; and

g. MICC signature, title and date.

The MICC record and service plan are provided for documenting/tracking MICC activity (see "EXHIBITS" at the end of this chapter for a sample of this form). Tracking and follow-up must also be documented in the progress notes. If the MICC is involved in the direct provision of medical or prenatal care services, the documentation must clearly differentiate MICC services from other service provisions to justify Medicaid reimbursement.

MICC Coordinator Transfers Within the Agency

The recipient may elect to have care coordination services provided by another MICC by choice or by necessity. In situations such as this, the MICC must coordinate activities with the new MICC by:

1. Updating the service plan to ensure that it is current;

2. Initiating contact with the new MICC by appointment/telephone to review the recipient's file and share significant information;

3. Notifying the appropriate providers of the change in status;

4. Meeting with the new MICC and recipient, if possible, to discuss and explain the transfer; and

5. Giving the care coordination record(s) to the new MICC. The record must indicate the reason for the transfer.

MICC transfers occurring within a single agency/local health department do not require the completion of an outcome report.

MICC Agency-To-Agency Transfers

The transfer of a recipient is appropriate in the following situations:

1. The recipient relocates to another community;

2. The original provider agency is unable to meet the recipient's needs (due to lack of staff and/or resources); or
3. The recipient requests transfer to another agency of her choice.

If a MICC recipient transfers from one agency to another agency, the following steps must be completed:

1. Originals of the enrollment forms must be retained by the transferring agency (DMAS-50, DMAS-51; DMAS-16, DMAS-17; DMAS-52; and DMAS-55).

2. The transferring agency must complete a pregnancy or infant outcome report (DMAS-53 or DMAS-54) and forward it to DMAS (see "EXHIBITS" at the end of this chapter for a sample of these forms).

3. A copy of the enrollment forms must be forwarded to the receiving agency (DMAS-50, DMAS-51; DMAS-16, DMAS-17; DMAS-52; and DMAS-55).

4. A new recipient agreement must be signed by the new care coordinator and the recipient. This form is retained in the recipient's record (DMAS-55).

5. The new provider must update information on the Maternal and Infant Care Coordination Record (DMAS-50 or DMAS-51), and update the service plan (DMAS-52) to ensure that they are current.

6. The new provider must forward to DMAS, a copy of the Maternal and Infant Care Coordination Record with the word "TRANSFER," the transfer date, and the new provider number written across the top of the form (DMAS-50 or DMAS-51). This process is necessary to assure reimbursement for the new provider. Send the form to:

   Managed Care Unit
   Department of Medical Assistance Services
   600 East Broad Street, Suite 1300
   Richmond, Virginia 23219

Refusal of the Recipient to Continue Participation in Maternal and Infant Care Coordination Services

The recipient may elect to discontinue maternal and infant care coordination services altogether. Every attempt should be made to encourage the recipient to continue this service and to understand possible problems which may occur if the services are discontinued. This requires a high degree of sensitivity and judgment to ensure the recipient's rights are protected and, at the same time, making sure she understands what this means. Some options which may be available include:

1. Transferring the recipient to another MICC;

2. Counseling by a third party; and

3. Following-up after the termination to determine if the recipient has changed her mind.

If the recipient maintains her decision to discontinue the service, ensure that she is given appropriate information concerning the service plan and other community resources

available to help meet her needs.

The service plan must be updated to reflect the recipient's final care coordination service status; providers must be notified of the recipient's decision; and the termination reason must be included in the MICC record.

Case Closing

MICC services are covered for the high-risk mother for up to 60 days after termination of the pregnancy and for the high-risk infant up to age two (2). Certain services are required of the MICC to assure a smooth case closure and prevent a feeling of abandonment by the recipient.

1. Assist the recipient in locating those routine community services which may be available to her and her newborn;

2. Provide any information which could help the recipient meet needs that will continue beyond the conclusion of MICC services;

3. Review with the recipient the skills and knowledge obtained and the problems overcome;

4. Notify active providers, as appropriate, that MICC services are being discontinued; and

5. Complete the Pregnancy or Infant Outcome Report (Exhibits IV.7 and IV.8) and submit, within 30 days after case closure, to:

Managed Care Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Attention: BabyCare

The outcome reports are critical to the evaluation of the BabyCare Program's success or failure in reducing infant mortality and morbidity. For this reason, the MICC must take care in completing each element in the report. When the outcome report has been received by DMAS, the MICC will be sent a notification of its receipt. Billing for the final month of care coordination will not be made until the Notification of Receipt of Outcome letter has been received. If the MICC does not receive the Notification of Receipt of Outcome letter, the MICC must call the Managed Care Unit at DMAS.

FORMS REQUIRED FOR PAYMENT PREAUTHORIZATION FOR MICC

Medicaid will assume the payment responsibility for MICC services only after the Department of Social Services has determined that the individual is financially eligible for medical assistance for the dates on which the services are to be provided. Because

Medicaid payment for Maternal and Infant Care Coordination may be made only for high-risk pregnant women or infants, Medicaid will not pay for MICC services without authorization by DMAS.

To receive authorization for payment, the MICC must submit to DMAS one copy each of the (see "EXHIBITS" at the end of this chapter for samples of these forms):

- Risk Screen
- Recipient's Letter of Agreement
- Maternal or Infant Care Coordinator Record
- Service Plan, Initial

These must be submitted together as a package.

Following the receipt of the required documentation, DMAS will preauthorize payment and send an authorization letter to the MICC so Medicaid may be billed for services rendered. No claims will be paid prior to this authorization.

The enrollment forms required for payment authorization must be sent to:

Managed Care Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Attention: BabyCare

SERVICE REQUIREMENTS FOR EXPANDED PRENATAL SERVICES

Referrals For Expanded Prenatal Services:

In addition to the comprehensive prenatal services that are provided to all Medicaid participants, the BabyCare Program offers expanded prenatal services for any pregnant woman such as:

- Patient Education Classes: Smoking Cessation, Childbirth classes, and Parenting;
- Nutrition counseling/assessment; and
- Homemaker services for patients for whom the physician has ordered complete bed rest.

Referrals for Expanded Prenatal Services may occur at any time during the pregnancy by either the primary care provider or the care coordinator. A copy of the risk screen must be forwarded to the provider of expanded prenatal services. The homemaker referrals are made only by a physician. The type of referral will be determined by a risk screen completed on the recipient by the primary-care provider. In most instances, a pregnant woman who requires expanded services will also have been referred to care coordination. To have the maximum impact on the pregnancy outcome, coordination between the care

coordinator or primary care provider who made the referral and the expanded prenatal service providers must exist.

The primary care provider or care coordinator must contact the provider of the expanded service(s) upon completion of the risk screen so that a referral is made in a timely manner. The referral date, name of the provider, and the service being rendered must be documented in the Service Plan (DMAS-52) by the care coordinator. The primary care provider, in the case where the woman is not being followed by a care coordinator, must also note the referral date, name of the provider, and the service being rendered in the recipient's medical record.

Expanded Prenatal Service Providers Response to Referral

Providers of expanded prenatal services shall be enrolled by Medicaid to provide these services.

1. **Patient Education Services** - The patient educator is responsible for offering group classes to the participant and documenting the participant's attendance and completion of the classes. In addition, the patient educator must notify the primary care provider and care coordinator of the dates of the scheduled classes and the dates on which the participant attended classes and the final recommendations for any follow-up or additional service needs for each BabyCare participant.

2. **Nutritional Services** - Upon receiving a referral by the primary-care provider or the care coordinator, the nutritionist must complete a written dietary assessment and offer any follow-up nutritional counseling indicated. (Medicaid reimbursement is limited to two follow-up nutritional counseling sessions). The nutrition must complete an assessment within 30 days of the referral from the primary care provider or care coordinator and record any concerns in the recipient's progress notes for the follow-up visits.

   The nutritionist must forward to the primary care provider or the care coordinator the nutritional assessment. Upon completion of the nutrition counseling, the nutritionist must provide the primary care provider and/or the care coordinator with a report of the progress of the individual and final recommendations.

3. **Homemaker Services** – To be enrolled for BabyCare homemaker services, a recipient must be referred by a physician and a recipient must have a risk identified on the risk screen. The provider of homemaker services must retain a copy of the risk screen.

   Homemaker services include those services necessary to maintain the household routine for pregnant and postpartum women when it is necessary as determined by a physician's written order that a recipient be on continuous bedrest. An RN, LPN, or Social Worker must provide supervision to the care providers. Duties may be performed by a companion, homemaker, nursing assistant, or home health aide.

The RN supervisor must make an initial home assessment visit prior to the start of care and develop a written plan of care with the recipient for the homemaker to follow. The aide may perform any household duties which the participant requires to enable complete bed rest ordered by the physician. The homemaker may not transport the recipient in the aide's personal car to an appointment or care for the children in a doctor's office. The aide is not allowed to perform any skilled nursing care procedures.

The homemaker agency and the recipient may decide the number of hours of care that are needed per day. If more than four hours/day are needed, this is acceptable as long as the maximum hours of 124 hours/31 days are not exceeded each month.

Medically necessary extensions may be requested from DMAS. To obtain approval of an extension, the MICC must obtain a letter of medical necessity from the physician stating a brief justification for the continued need for bed rest and the expected amount of time the recipient will need continued bed rest. If bed rest is required through delivery, include the due date of the recipient. A copy of the letter must be sent to the Managed Care Unit at DMAS, Attention: BabyCare.

The RN is also responsible for introducing the assigned aide to the participant and reviewing with the aide and the participant the duties the aide will be performing. The RN shall make supervisory visits as often as needed to ensure both the quality and appropriateness of services. If the recipient is authorized by DMAS to receive more than 31 days of homemaker services, the homemaker agency RN Supervisor must make additional supervisory visits at a minimum frequency of every 30 days. The aide must be present during the nurse supervisor's visit at least every other month. Flow sheets must be used by the homemaker/supervisor for documentation purposes. The homemaker's visit must be documented and signed by the aide and the recipient of services for each date of service.

SELECTED MEDICAID-COVERED SERVICES

The following information describes selected Medicaid-covered services and some services from other sources that the care coordinator may use for services planning and referral.

Home Health Services

Home health services, while not specifically a prenatal care service, are also available when ordered by a physician for pregnant women who are essentially homebound and whose medical complications require short-term, intermittent nursing care. Such services are provided by Medicaid-enrolled home health agencies according to a written plan of care.

Service coverage and limitations are described in the Medicaid *Home Health Manual*.

Family Planning Services

Family planning services are covered by Medicaid when rendered by Medicaid-enrolled public or private providers. These services include counseling, patient education, examination, and treatment as prescribed by a physician for the purpose of family planning.

Family Planning Waiver Services (Effective October 1, 2002)

Family planning services may be available for women who received a Medicaid reimbursed pregnancy related service on or after October 1, 2002, who are less than 24 months postpartum, and who have income less than or equal to 133% the Federal Poverty Guidelines. (Women who do not meet the alien requirements for full Medicaid coverage and whose labor and delivery was paid as an emergency service under Medicaid are not eligible to participate in the family planning waiver). Women enrolled in this waiver program are considered a specific Medicaid covered group and will only receive family planning services and sexually transmitted disease (STD) screening. Refer to the *Physician Manual*, Chapter IV, for a listing of specifically covered services. Additional information and eligibility determination is available at the local Department of Social Services.

EPSDT (Early and Periodic Screening, Diagnosis and Treatment Program)

EPSDT is Medicaid's preventive health care program for children and teens up to age 21. MEDALLION PCPs are required to provide or arrange for EPSDT screening services including immunizations. Fee-for-service recipients may contact the Managed Care HelpLine to locate EPSDT screening providers. The program provides for screening (regular checkups) and diagnostic services to determine if Medicaid recipients have physical and/or mental defects and to provide treatment and other measures needed to correct any defects or chronic conditions discovered. The goal of the EPSDT program is to promote the concept of a medical home for recipients. This is achieved when the recipient obtains both sick care and well care from the same provider.

RELATED PROGRAM S/SERVICES FOR PREGNANT WOMEN AND CHILDREN

In addition to BabyCare, several other programs are available to meet the medical, social, and educational needs of pregnant women and children.

Women, Infants and Children's Supplemental Food Program (WIC)

WIC is a supplemental food and nutrition education program that provides vouchers for the purchase of nutritious foods and dietary counseling to pregnant, postpartum or breastfeeding women and children under age five with special nutritional and financial needs. Any Medicaid-eligible individual who meets these criteria must be referred to his or her local health department for additional information and eligibility determination.

Head Start

Head Start is a federally-funded pre-school program which serves low-income children and their families.

There are four major components in Head Start as follows:

- **Education** - Head Start's educational program is designed to meet the individual needs of each child. It also aims to meet the needs of the community served and its ethnic and cultural characteristics.

- **Health** - Head Start emphasizes the importance of early identification of health problems. Since many children of low-income families have never seen a doctor or dentist, Head Start provides every child with a comprehensive health care program, including medical, dental, mental health and nutritional services.

Continued on Next Page

The comprehensive physical assessment performed by EPSDT will meet the requirements of the Head Start Program health assessment.

- **Parent Involvement** - Parents are the most important influence on a child's development. Parents are encouraged to participate in the Head Start program as volunteers or paid staff as aides to teachers and other staff members. Many parents serve as members of Policy Councils and Committees and have a voice in administrative and managerial decisions.

- **Social Services** - The social services component of Head Start represents an organized method of assisting families to assess their needs, and then providing those services that will build upon the individual strengths of families to meet those needs. Some of the activities that the social services staff use to assist families to meet their needs are: community outreach, referrals, family needs assessments, providing information about available community resources and how to obtain and use them, recruitment and enrollment of the children, and emergency assistance and/or crisis intervention.

For additional information, contact the local Head Start program or the Council on Child Day Care and Early Childhood programs at (804) 371-8603.

Early Intervention Program

Early intervention services are identified in the Part C amendment to the Individuals with Disabilities Education Act (IDEA). Part C provides for a discretionary grant program for states to plan, develop and implement a statewide, comprehensive, coordinated, interagency system of early intervention services to infants and toddlers with disabilities and their families.

The goals of the Program are:

- To enhance the development of disabled infants and toddlers and to minimize their potential for developmental delay;

- To reduce the education costs to society by minimizing the need for special education and related services after infants and toddlers with disabilities reach school age;

- To minimize the likelihood of institutionalization for individuals with disabilities and maximize their potential for independent living in society; and

- To enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities.

As defined in the regulations, "infants and toddlers with disabilities" means individuals from birth through age two who need early intervention services because they are developmentally-delayed.
"Early intervention" includes a multidisciplinary assessment and a written Individualized Family Services Plan (IFSP) developed by the multi-disciplinary team and the parents.

Early intervention services may include audiology; case management services; family training, counseling, and home visits; health services; medical services (for diagnostic and evaluation purposes only); nursing services; nutrition services; occupational therapy; physical therapy; psychological services; social work services; special instruction; speech-language pathology; and transportation. For more information, contact:

Virginia Department of Mental Health, Mental Retardation
and Substance Abuse Services
Early Intervention Office
Post Office Box 1797
Richmond, Virginia 23214

Telephone (804) 786-3710

Resource Mothers Programs

Teenagers are a group at high risk for poor birth outcome, both medically and socially. The Resource Mothers Program trains and supervises lay women to serve as a social support for pregnant teenagers and teenage parents of infants. The program is recognized for its role in bringing low-income pregnant teenagers into prenatal care and providing them with the support needed to make use of health care and other community services, to follow good health care practices, and to continue in school.

The Virginia Resource Mothers Program is a joint effort of the Department of Health, the Department of Medical Assistance Services and local community agencies. Medicaid currently supports nine programs serving 19 localities across Virginia as a maternal outreach service. For further information, contact the Division of Maternal and Child Health, Virginia Department of Health, (804) 786-7367.

Local Departments of Social Services (DSS)

Local departments of social services are agencies where temporary public assistance eligibility determinations are made and social services are provided to recipients. Other services available at DSS include Food Stamps and Fuel. For additional information contact the local DSS agency.

Community Mental Health Agencies

Community services boards provide outpatient mental health, mental retardation, and substance abuse services. Some of these services are covered by Medicaid and others are offered on a sliding-scale fee basis.

Healthy Start

Healthy Start is a grant program designed to enhance the existing perinatal health services for six areas within Virginia that have high need based on infant mortality, post neonatal mortality, teen pregnancy, and poverty statistics. The areas of Virginia include Norfolk, Portsmouth, Petersburg, Westmoreland County, Mecklenburg County, and Clifton

Forge/Covington. In addition, the funding expands the Fetal/Infant Mortality Review in each of the seven Regional Perinatal Coordinating Council areas and expands the Resource Mothers Program and nutrition services. Information about Health Start can be obtained by contacting the Health Start Coordinator at the Virginia Department of Health Division of Women's and Infant's Health at 1-804-786-9110.

Teen Pregnancy Prevention Program

The Teen Pregnancy Prevention Program is administered by the Virginia Department of Health Division of Child and Adolescent Health. This program is designed to reduce teen pregnancy in Virginia by assessing the problem, assuring program services with effective leadership and program development, and evaluation to promote replication of effective approaches. The major activities of this program include assessing and monitoring trends in adolescent pregnancy, providing community leadership for planning and policy development, providing quality assurance services for the local Teen Pregnancy Prevention Initiatives (TPPI) and Better Beginnings Coalitions (BBC) and assisting other communities to develop teen pregnancy prevention coalitions and programs.

Services provided include information and referrals, training for TPPI, BBC, parents, educators, physicians, community groups, and others and technical assistance. Teen Pregnancy Prevention Initiatives are located in seven Virginia Health Departments across the state, including Alexandria, the Eastern Shore, Crater Health District, Norfolk, Portsmouth, Richmond, and Roanoke. Additional information about the Teen Pregnancy Prevention Program can be obtained by contacting the Virginia Department of Health Division of Child and Adolescent Health Teen Pregnancy Prevention Coordinator at 1-804-786-6776.

Other Resources

All care coordinators must develop knowledge of local resources, including but not limited to, Children's Specialty Services clinics, local health departments, the Department of Mental Health/Mental Retardation and Substance Abuse Services, Babies Can't Wait, the Department of Rehabilitative Services, the Department for the Visually Handicapped, the Department for the Deaf and Hard of Hearing, and private agencies, such as the American Red Cross, the American Heart Association, the Easter Seal Society, and the Cystic Fibrosis Foundation.

MATERNITY RISK SCREEN INSTRUCTIONS

PURPOSE:

1. To identify high-risk maternity patients eligible for care coordination.
2. To identify maternity patients at risk for poor pregnancy outcome who need additional prenatal care services (homemaker, patient education and nutritional counseling).

PROVIDER: The risk screen is performed by the primary care provider. The risk screen must be completed and signed by a licensed physician, certified nurse practitioner, or certified nurse midwife. The patient may be referred during pregnancy for MICC services for any of the risk conditions which are listed on the Risk Screen form. The risk conditions on the form should not be altered by the primary provider. Suggestions or information regarding the recipient or referrals may be written in the instructions section at the bottom of the form. The primary care provider must sign the form including his or her title. Use Z9001 (Maternity Risk Screen) to bill for the maternity risk screen.

REFERRALS: If care coordination is deemed not necessary, document the other services the recipient will receive, i.e., routine maternity care.

DEFINITION:

Underweight: Less than 90% of the Standard Weight.

Inadequate weight gain: Less than 2 1/4 lbs. per month in the second and third trimesters or less than 9 lbs. by 20 weeks, if normal weight. Less than 3 lbs. per month if underweight.

Excessive weight gain: More than 7 lbs. per month for two months if normal or overweight.

Height Without Shoes	90% Standard Weight	Height Without Shoes	90% Standard Weight
4'8"	91	5'5"	119
4'9"	94	5'6"	122
4'10"	96	5'7"	126
4'11"	99	5'8"	130
5'0"	102	5'9"	133
5'1"	104	5'10"	137
5'2"	106	5'11"	140
5'3"	111	6'0"	144
5'4"	115		

DISTRIBUTION OF COPIES: One (1) copy must accompany each referral to the MICC agency. The original must be retained by the physician in the recipient's

medical chart.

See “EXHIBITS” at the end of this chapter for a sample of this form.

INFANT RISK SCREEN INSTRUCTIONS

PURPOSE: To identify high-risk infants who need MICC services.

PROVIDER: The risk screen is performed by the primary care provider. The risk screen must be completed and signed by a licensed physician certified, certified nurse practitioner, or certified nurse midwife. The risk conditions on the form should not be altered by the primary care provider. Suggestions or information regarding the recipient or referrals may be written in the instructions section at the bottom of the form. The primary provider must sign the form including his or her title. Use Z9011 (Infant Risk Screen) to bill for the infant risk screen

REFERRALS: If care coordination is deemed not necessary, document the other services the recipient will receive, i.e., routine pediatric care.

DISTRIBUTION OF COPIES: One copy must accompany the referral to the MICC agency. The original must be retained in the recipient's medical chart.

EXHIBITS

TABLE OF CONTENTS

MATERNITY RISK SCREEN

The risk screen is designed to capture high risk pregnant women as identified by the BabyCare program. Risks must not be altered. Please check all risks that apply to the recipient and make the appropriate referral(s).

Patient Name _____ Medicaid # _____ EDC _____

A. MEDICAL

1. _____ Hypertension, chronic or preg. induced
2. _____ Gestational diabetes/diabetes
3. _____ Multiple gestation (twins, triplets)
4. _____ Previous preterm birth < 5½ lbs.
5. _____ Advanced maternal age, > 35 yrs.
6. _____ Medical condition, the severity of which affects pregnancy, document below
7. _____ Previous fetal death

Substance abuse	# days/week used	# times/day used
8. Alcohol		
9. Cocaine/crack		
10. Narcotics/heroin		
11. Marijuana/hashish		
12. Sedatives/ tranquilizers		
13. Amphetamines/ diet pills		
14. Inhalants/glue		
15. Tobacco/cigarette		
16. Other, please specify _____		

B. SOCIAL

1. _____ Teenager 18 yrs or younger
2. _____ Non compliant with medical directions or appointments
3. _____ Mental retardation or history of emotional/mental problems
4. _____ Abuse/neglect during pregnancy
5. _____ Shelter, homeless or migrant

C. NUTRITION

1. _____ Prepregnancy underweight/overweight inadequate or excessive weight gain
2. _____ Obstetrical or medical condition requiring diet modification, document condition below
3. _____ Poor diet or pica
4. _____ Teenager 18 years or younger

REFERRALS

1. _____ Care Coordination 2. _____ Nutritional Counseling 3. _____ Homemaker 4. _____ Parenting/Childbirth Class
5. _____ Glucose Monitor with nutrition counseling 6. _____ Smoking Cessation 7. _____ Substance Abuse Treatment
8. _____ No Care Coordination _____

PROVIDERS COMMENTS OR SUGGESTIONS _____

SIGNATURE/TITLE _____ SCREENING DATE _____

SIGNATURE PRINTED _____ PROVIDER # _____

DMAS 16 Rev. 8/93 F3/VA29728

Referral to High-Risk Care Coordination

INFANT RISK SCREEN

Research supports the fact that indigent mothers and their high risk infants often need a combination of medical and non-medical services to assure positive infant health.

The risk screen is designed to capture high risk infants as identified by the BabyCare Program. Risks must not be alted. Please check all risks that apply to the recipient and make the appropriate referral.

PATIENT NAME: _____ VMAP ID# _____

PARENT/GUARDIAN NAME: _____

PATIENT ADDRESS: _____ PHONE# _____

A. MEDICAL

- ☐ Diagnosed developmentally delayed/neurologically impaired
- ☐ Diagnosed medically significant genetic condition (including sickle cell disease)
- ☐ Birth weight 1750 grams (3lbs., 14 oz.) or less
- ☐ Chronic illness
- ☐ Dignosed with fetal alcohol sydrome (FAS)
- ☐ Medical high risk infant and pediatric care needed, but not avaliable 24 hours a day
- ☐ Medical condition(s) the severity of which requires care coordination (document medical condition below)
- ☐ Born exposed to an illegal drug in utero
- ☐ Failure to thrive or flattening of growth curve

B. SOCIAL

- ☐ Parent/guardian unable to communicate due to language barriers (e.g. non-English speaking, illiterate)
- ☐ Maternal absence (illness, incarceration, abandonment)
- ☐ Parental substance abuse/addiction (only includes father if living in home)
- ☐ Caregiver's handicap presents risk to infant (physically impaired, hearing impaired, vision impaired)
- ☐ Caregiver mental illness/mental retardation
- ☐ Shelter, homeless or migrant worker
- ☐ Mother 18 years or younger
- ☐ History of suspected abuse/or neglect
- ☐ Non compliant with follow-up visits/screening visits and medical direction for this infant.

C. NUTRITION

- ☐ Congenital abnormalities affecting ability to feed or requiring special feeding techniques; poor sucking, severe or continuing diarrhea or vomiting; other conditions requiring diet modification
- ☐ Inadequate diet

REFERRAL: ☐ Care Coordination

☐ No Care Coordination - What services will the recipient receive? _____

PROVIDER COMMENTS, SUGGESTIONS, OR INSTRUCTIONS: _____

_____

SIGNATURE/TITLE _____ SCREENING DATE _____

SIGNATURE PRINTED _____ PROVIDER I.D.# _____

Revised 03/93 WPPSHBC #454 DMAS 17

Referral to High-Risk Care Coordination

VIRGINIA MEDICAL ASSISTANCE
CARE COORDINATION

Letter of Agreement

The Department of Medical Assistance Services wants you to be healthy and have a healthy baby. Your Maternal and Infant Care Coordinator (MICC) can help you find and get the services you or your infant may need. Your coordinator can help you get:

Medical Care
WIC Services
Home Health Services
Transportation
Information About Other Services

And if you are pregnant:
Nutrition Services from Registered Dietitians
Homemaker Services
Information About Pregnancy and Child Care

Your MICC is there to help you!

Your part in care coordination is to:

- Get prenatal or well-child care and WIC as soon as possible.
- Keep all appointments.
- Tell your Coordinator about your needs during pregnancy, or as a new mother.
- Let your Coordinator know how to reach you.
- Do your best to follow your plan for having a healthy baby.

Both a coordinator and the client must agree to sign this letter of agreement to begin care coordination services. Care coordination services may be delivered by one or more coordinators in the agency.

I understand my part and wish to get care coordination services. Prenatal care and other Medicaid benefits will not stop if I choose not to get care coordination services. I agree my care coordinator may share medical information about me or my infant with my health-care providers.

I understand my part of care coordination services and will work with the client to help her receive the services she needs.

_____
Name of Client

_____
Coordinator Signature

_____
Medicaid Eligibility #

_____
Coordinator Provider #

_____
Signature of Client/Date

_____
Date

_____
Telephone Number

_____
Name and Provider # of Referring Physician

DMAS-55 8/93
SHBC #1434

Client Last Name _____ First Name _____ MI _____

Street Address _____

City _____ State _____ Zip _____ City/County of Residence _____

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MATERNAL CARE COORDINATION RECORD

Medicaid #		**COORDINATOR NAME**
Birthdate	Occupation	**Coordinator Agency**
Marital Status	Race	**Coordinator Address**
Education Level	DMAS Provider #	**First MICC Contact** Date (D/M/Y)
# of Live Births	Abortion	**Assessment Completed** Date (D/M/Y)
Miscarriages	Stillbirths	**Service Plan Completed** Date (D/M/Y)
Client Home Phone		Work Phone
Emergency Contact		Emergency Contact Phone
Primary Care MD		Primary Care Phone
EDC	Hospital	Wks. gestation when prenatal care began

PSYCHOLOGICAL ASSESSMENT

	Yes	No		Yes	No		Yes	No
1. Previous poor pregnancy exp.			8. Conflict/violence in home			15. Housing needs		
2. Poor support system			9. Family has urgent health needs			16. Transportation need		
3. Significant anxiety			10. Insufficient funds for food			17. School needs		
4. Drug usage			11. Difficulty obtaining food stamps			18. Employment need		
5. Alcohol usage			12. Poor planning ability			19. Homeless		
6. Tobacco usage			13. Poorly motivated			20. Neglect		
7. Religious/ethnic factors affecting pregnancy			14. Childcare needs/poor parenting knowledge			21. Mental retardation/ emotional problems		

GENERAL MEDICAL ASSESSMENT

	Yes	No		Yes	No		Yes	No
1. Multiple gestation			4. Medical condition affecting pregnancy			7. Limited access to care		
2. Prior preterm <5 ½ lb>			5. Lack of risk knowledge/poor pregnancy information			8. Advanced maternal age >35		
3. History of genetic disorder			6. Previous fetal death			9. Multiple medical providers		

NUTRITIONAL ASSESSMENT

	Yes	No		Yes	No		Yes	No
1. Pregnancy overwgt.			5. Medical condition affects diet			9. Poor basic diet info		
2. Pregnancy underwgt.			6. Special diet prescribed			10. Inadequate cooking facility		
3. Inadequate wgt. gain			7. Nausea/Vomiting			11. Age 18 or younger		
4. Excessive wgt. gain			8. Food cravings/pica			12. Anemia		

SUBSTANCE ABUSE USAGE PRIOR TO START OF PREGNANCY

	Days/ Weeks	Times/ Day		Days/ Weeks	Times/ Day		Days/ Weeks	Times/ Day
1. Alcohol			4. Marijuana/hashish			7. Inhalants		
2. Cocaine/crack			5. Sedatives/tranquilizers			8. Tobacco/cig		
3. Narcotics/heroin/codeine			6. Amphetamines/diet pills			9. Other		

SUBSTANCE ABUSE USAGE AT CURRENT POINT IN PREGNANCY

	Days/ Weeks	Times/ Day		Days/ Weeks	Times/ Day		Days/ Weeks	Times/ Day
1. Alcohol			4. Marijuana/hashish			7. Inhalants		
2. Cocaine/crack			5. Sedatives/tranquilizers			8. Tobacco/cig		
3. Narcotics/heroin/codeine			6. Amphetamines/diet pills			9. Other		

CLIENT REFERRALS	**DATE**	**Outcome**		**Date**	**Outcome**	**POSTPARTUM REFERRAL**	**Date**
WIC			Homemaker			Family Planning	
Nutrition Counseling			Tobacco Cess.			EPSDT	
Parenting/Child			Substance Abuse			Infant WIC	
						DSS Medicaid Eligibility Re-determination	

SIGNIFICANT FINDINGS

DMAS-50 rev. 10/02 COORDINATOR SIGNATURE _____ DATE _____

SERVICE PLAN

Recipient Name: _____ Recipient Medicaid #: _____

Primary Care Provider Aware of Recipient Enrollment in BabyCare

_____

Date

NEED NO.	DATE	IDENTIFIED NEEDS/PROBLEMS	PLAN	FOLLOW UP

I agree with this service plan and will work with my care coordinator to get the services I need.

Client's Signature: _____ Date: _____

Care Coordinator's Signature: _____ Date: _____

SERVICE PLAN

Recipient Name: _____ Recipient Medicaid #: _____

Primary Care Provider Aware of Recipient Enrollment in BabyCare

_____

Date

NEED NO.	DATE	IDENTIFIED NEEDS/PROBLEMS	PLAN	FOLLOW UP
1	5/6/98	Smoking	**1.** Provide literature on harmful effects of smoking on fetus. **2.** Encourage client to cut down or quit smoking by developing with client a realistic schedule to decrease number of cigarettes smoked per day. **3**. Refer to smoking cessation classes.	**1.** Assess client's comprehension of literature. **2.** Monitor decreases in smoking each contact. **3.** Reinforce information
2	5/6/99	Inadequate Diet	**1.** Review dietary needs during pregnancy and reinforce nutritionist's recommendation**.** **2.** Monitor weight gain and hemoglobin**.**	**1.** Repeat diet recall assess understanding of dietary needs and changes made. 2. Reinforce nutritionist's recommendations 3. Graph weights and refer, if indicated
3	5/6/99	Lack of knowledge re: infant/child care needs	**1.** Teach basic infant care and feeding. **2**. Teach growth and development.	**1.** Assess comprehension and further teaching needs. 2. Supply and review pamphlets and videos with client.

I agree with this service plan and will work with my care coordinator to get the services I need.

Client's Signature: _____ Date: _____

Care Coordinator's Signature: _____ Date: _____

Client Last Name:	First:	MI:	**VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES**
Street Address:			
City/County of Residence:			**INFANT CARE COORDINATION RECORD**
Medicaid ID#:			Coordinator Name:
Birthdate:	Soc. Sec. #:		Coordinator Agency:
Race:	Sex:		DMAS Provider ID#:
Primary Physician Name:			Coordinator Address:
Physician Phone:			DATE
Caretaker Name:			First MICC Contact
Relationship/Guardianship Status:			Assessment Completed
Address, if different:			Service Plan Completed
Phone: (Home)	(Work)	Occupation:	Case Closed
Maternal Education Level:	Age:	Marital Status:	Infant Outcome Report

ASSESSMENTS

PSYCHOSOCIAL	YES	NO		YES	NO		YES	NO
1. Poor previous parenting experience	___	___	8. Conflict/Violence in the home	___	___	16. Care needs/poor child care knowledge	___	___
2.. Poor support system	___	___	9. Family has urgent health needs	___	___			
3. Significant apprehensions/anxiety	___	___	10. Insufficient money for food	___	___	17. Housing needs	___	___
4. Drug use	___	___	11. Difficulty obtaining food stamps	___	___	18. Transportation needs	___	___
5. Alcohol use	___	___	12. Maternal absence	___	___	19. School needs	___	___
6. Tobacco usage	___	___	13. Protective services case	___	___	20. Homeless	___	___
7. Religious/Ethnic/Cultural factors affecting healthcare	___	___	14. Poor emotional bonding	___	___	21. Neglect	___	___
			15. Mental retardation/emotional problems	___	___	22. Poor planning by caretaker	___	___
						23. Unmotivated caretaker	___	___

GENERAL MEDICAL	YES	NO		YES	NO		YES	NO
1. Apnea	___	___	5. Lack of risk knowledge	___	___	9. Care giver handicap	__	__
2. Sibling morbidity/mortality	___	___	6. Drug exposure in utero	___	___	10. Multiple medical providers	__	__
3. Genetic disorder	___	___	7. Limited access to care	___	___	11. Birth weight <3 lbs 14 oz	__	__
4. Chronic illness			8. Developmental delay					

NUTRITIONAL	YES	NO		YES	NO		YES	NO
1. Poor use of WIC benefits.	___	___	4. Poor use of special formula	___	___	7. Acute illness diet needs	___	___
2. Poor basic diet information.	___	___	5. Needs diet/feeding modification	___	___	8. Poor/excessive weight gain	___	___
3 . Breast feeding problems	___	___	6. Inadequate sucking	___	___	9. Anemia	___	___

SIGNIFICANT FINDINGS:

APPOINTMENTS: K = KEPT 0 = DID NOT KEEP APPOINTMENT

DATE	TYPE	K/O	COMMENTS	DATE	TYPE	K/O	COMMENTS

CLIENT REFERRALS	**DATE**	**OUTCOME**	WIC:
Child Specialty Services			First EPSDT Visit :
Protection Services			Early Intervention Services:
Other			
			Coordinator Signature/Date

DMAS-51 Rev. 6/99

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PREGNANCY OUTCOME REPORT

1. Last Name _____ 2. First _____ 3. MI _____ 4. Other Last Name _____

5. Date of Birth (M/D/Y) _____ 6. City/County of Residence _____ 7. Race: Enter appropriate number in space provided. _____

8. Medicaid # _____ 7. Previous # if applicable _____

9. Provider # _____ 10. Provider Name _____
Address _____
_____

1. White
2. Black
3. Am. Indian
4. Asian
5. Hispanic
6. Other _____

11. Enter number of reason recipient is no longer requiring service _____

1. Pregnancy ended	4. Lost to follow-up	7. Died
2. Dropped out of prenatal care	5. Eligibility cancelled	8. Moved
3. Transfer to other MICC agency	6. Problem resolved	9. Other (Specify):

12.. Pregnancy Outcome: _____

Instruction: Enter pregnancy outcome number in the space above only if the answer to item 11 is "1. PREGNANCY ENDED"

1. Live birth	3. Therapeutic abortion	5. Fetal death
2. Spontaneous abortion	4. Elective abortion	6. Other:

13. Infant's Live Birth Data
Instruction: Complete item 13 only if answer to item 12 is "1. LIVE BIRTH"

	INFANT #1	**INFANT # 2**
Birth Weight lbs. and ozs.		
Birth Date		
APGAR Score 1 min **5 min**		

14. Weeks gestation at time of birth _____

15. Infant Risk Screen

a. Has Physician completed risk screen?	1-Yes	2-No	**c.** If yes, has the infant been referred to care coordination?	1-Yes	2-No
b. If yes, was the infant classified as " high risk"?	1-Yes	2-No	**d.** If yes, was the infant born with morbidity?	1-Yes	2-No
16. Is the Infant receiving EPSDT services?	1-Yes	2-No	**17. Is the infant receiving WIC services?**	1-Yes	2-No

18. Enter number of weeks gestation when mother began prenatal care _____

19. Total number of prenatal visits by mother during this pregnancy _____

20. Did mother receive WIC during pregnancy?	1-Yes	2-No	**21. Did mother receive postpartum or family planning exam?**	1-Yes	2-No

22. Client Needs
Instruction: Indicate needs that were met through care coordinator assistance by entering "1" in the appropriate space(s).
Indicate client needs that were not met at the completion of care coordination by entering "2" in the space(s).

1. Child Care		5. Homemaker Ser.		9. Psychological		13. Smoking Cessation	
2. Food Stamps		6. Home Health Ser.		10. Job Training		14. Glucose Monitoring	
3. Housing		7. Employment		11. Transportation		15. Parenting/Childbirth	
4. Nutrition Ser.		8. School Enrollment		12. Substance Abuse Treatment		16. Family Planning	

12. Substance abuse at time of delivery
INSTRUCTION: Item 23 must be completed if substance abuse was indicated on Maternal Care Coordination Record (DMAS-50)

	# Days/Week	# Times/Day		# Days/Week	# Times/Day
Alcohol			Sedatives/Tranquilizers		
Cocaine/Crack			Amphetamines/Diet Pills		
Narcotics/Heroin			Inhalants/Glue		
Marijuana/Hashish			Tobacco/Cigarettes		
			Other (Specify):		

Coordinator's Signature _____ Date _____

DMAS-53 rev. 10/02

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES CARE COORDINATION
INFANT OUTCOME REPORT

1. Last Name	2. First Name	3. M.I.	4. Other Last Name
5. Date of Birth (Mo/Day/Year)	6. City/County of Residence		9. Provider I.D. #
7. Race 1 - White 2 - Black 3 American Indian 4 - Asian 5 - Hispanic 6 - Other			10. Provider Name and Address
8. Medicaid ID # _ _ _ _ _ _ _ _ _ _ _ _	Previous # if applicable _ _ _ _ _ _ _ _ _ _ _ _		

11. Enter the infant's birthweight and Apgar scores:

A. Birthweight: lbs. ____ ozs. ____

B. Apgar Scores: 1 min. ____ 5 min. ____

12. Enter reason infant is no longer receiving care coordination services: Date infant closed: _____

1 - reached age two
2 - dropped out of well-child care
3 - transfer to other MICC agency
4 - lost to follow-up
5 - eligibility cancelled
6 - problem resolved
7 - died
8 - moved
9 - other _____

Instruction: Complete items 13 & 14 only if answer to item 12 is "Died".

13. Enter the infant's age at death (months and weeks): mos. ____ wks. ____

14. Enter primary cause of infant's death:

1 - accident
2 - congenital abnormality
3 - birth trauma
4 - noncongenital illness

Instruction: Complete items 15 through 17 only if answer to item 12 is "Died" or "Reached Age Two."

15. Enter total number of prenatal visits by mother during this pregnancy: ____

16. Enter number of weeks gestation when mother began prenatal care: ____

17. Indicate if mother received care coordination services during this pregnancy: ____
1 - Yes 0 - No

Instruction: Complete items 18 through 22 only if answer to item 12 is "Reached Age Two."

18. Enter child health status at age two:

1 - normal health & development
2 - congential abnormality
3 - developmentally delayed
4 - non-congenital disease

19. Enter child's living situation at age two:
1 - with parent/guardian 2 - foster care placement 3 - long term care facility

20. Enter total number of EPSDT visits during first two years: ____

21. Indicate if child is receiving WIC benefits: ____
1 - Yes 0 - No

22. Enter child's height and weight at age two:

A. Height: ft. ____ ins. ____

B. Weight: lbs. ____ ozs. ____

23. Client Needs

Instruction: Indicate needs that were met through care coordinator assistance by entering "1" (one) in the appropriate block(s). Indicate client needs that were not met at the completion of care coordination services by entering "2" (two) in the appropriate block(s).

____ 1. child care	____ 4. nutrition counseling	____ 7. employment	____ 10. job training
____ 2. food stamps	____ 5. parenting education	____ 8. counseling	____ 11. transportation
____ 3. housing	____ 6. home health services	____ 9. school enrollment	

_____
Coordinator's Signature/Date

OMAS-52 03/92 (WPPMOJ #95)

BABYCARE ENROLLMENT/DISENROLLMENT PROBLEMS

Agency Name_____ Agency Provider #_____

Agency Address_____

Contact Name_____ Contact Phone_____ Fax # _____

Recipient ID No.	Recipient Name	Description of Enrollment Problem	Resolution of Enrollment Problem For use of DMAS staff only

If the recipient's Medicaid ID number has changed, provide both the original and the current number.

Use this form to notify DMAS of problems due to changes in the Medicaid number, enrollment to an incorrect provider number, incorrect disenrollment, or other problems with the BabyCare enrollment process.